Health Insurance Premium Rate Reviews in Maryland

Background

Maryland requires health insurance rates to be approved by the Insurance Commissioner before they can be implemented. The Commissioner is authorized to approve, deny or modify rates in the individual, small group and large group insurance markets. In July 2011, the U.S. Department of Health and Human Services determined Maryland's rate review process to be effective. That means the Federal Government will defer to the State on rate decisions.

What Goes Into Health Insurance Rates

Rates are driven by a variety of factors, including the insurance carrier's anticipated claims and administrative costs, the cost of medical services, and how often consumers use those services. In addition, rates may rise because more people – including some who previously were denied because of the higher risk they pose– have joined the pool of people with health insurance.

Under the Affordable Care Act (ACA), health plans are required to increase access to their coverage. Beginning January 2014:

- No one may be denied coverage because of pre-existing conditions.
- Lifetime dollar limits are no longer allowed. Beginning in January 2014, annual dollar limits on policies purchased since March 2010 also will be prohibited.

The financial risk associated with these changes is spread out among all the people in the pool. The ACA includes programs designed to soften the impact on rates when the pool is expanded. These programs – Reinsurance, Risk Corridors and Risk Adjustment, or the 3Rs – reduce the risk insurance companies acquire when they cover someone who uses more services or more expensive services.

Who Is Not Affected

Coverage provided by employers who self-insure and by Federal plans, such as Medicare, Tricare and federal employee plans, is not affected by these ACA provisions. Approximately two-thirds of Marylanders receive health insurance through such plans.

What Is an Actuarial Review?

When a health insurance company files proposed premium rates, the MIA's Office of the Chief Actuary is responsible for reviewing and analyzing the request. Actuarial review is a complex, multifaceted examination. No two rate filings are identical. In their filings, companies provide projections of claims over a specified period. Extensive documentation and supporting data are included. These documents describe the assumptions and methods used in support of the rates. Filings must conform to applicable requirements of the national Actuarial Standards of Practice. In addition, companies must show that their proposed rates are not excessive in relation to benefits, inadequate, or unfairly discriminatory.

Each filing receives careful, thorough scrutiny. It is the responsibility of the actuarial reviewer to apply professional standards and judgment when considering factors relevant to a rate filing. The MIA's actuaries evaluate and probe the assumptions upon which a company's filing is based. When the MIA has questions or concerns about a filing, one or more objection letters are forwarded to the company and the company must provide additional information to support its assumptions or conclusions. After the review process is complete, the Office of the Chief Actuary makes a recommendation to the Insurance Commissioner, who is the ultimate decision maker. The Commissioner must disapprove or modify a proposed rate filing if the proposed premium rates appear, based on statistical analyses and reasonable assumptions, to be inadequate, unfairly discriminatory, or excessive in relation to benefits. In determining whether to disapprove or modify a premium rate filing, the Commissioner must consider all relevant factors. A company may only charge policyholders those rates approved by the Insurance Commissioner.

What If The Assumptions Prove to Be Wrong?

Under the Affordable Care Act, insurance companies in the individual and small group markets must spend at least 80 cents of every premium dollar on paying medical costs. In the large group market, the requirement is 85 cents of every dollar dedicated to medical costs. This is referred to as the medical loss ratio, or MLR. If insurers do not meet their MLR targets, they must pay rebates to their policyholders. Rebates were issued for the first time in 2012.

For more information about the Maryland Insurance Administration's rate review process, go to www.mdinsurance.state.md.us/sa/docs/documents/consumer/publicnew/faq-healthinsurancerates.pdf.